OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE (MANDATORY)

EMPLOYEE: Can you read (circle one): YES NO

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (Please Print).

Name: ___________________________ Date: ___________________________

Date of Birth: _________________ Age: _________________

☐ Male  ☐ Female  Height: _________ Weight: _________________

Employer: ___________________________ Job Title: ___________________________

Work Area: ___________________________ Supervisor: ___________________________

Phone number where you can be reached to answer questions by the health care professional who reviews this questionnaire. (Include area code): ___________________________

The best time to call you at this number (normal working hours): ___________________________

Has your employer told you how to contact the health care professional who will review this questionnaire?

☐ Yes  ☐ No

Check type of respirator you will use (you may check more than one category)

☐ Dust Mask (N, R, or P disposable respirator filter - mask, non cartridge type)

☐ Half -- or full-face piece type  ☐ Power-air purifying  ☐ Supplied air

☐ Hood/Helmet  ☐ Escape

☐ SCBA/air tank  ☐ Non-powered cartridge or canister

☐ Disposable  ☐ Non-Disposable  ☐ Other ___________________________

Have you worn a respirator before?  ☐ Yes  ☐ No  If “yes”, what type(s): ___________________________

At the end of each section you will find space to document additional information regarding any “YES” answers. Please include dates, physician’s name, follow-up care, and indicate if this is an ongoing problem or if you have had surgery. If you need more space use the back of page 3.

Part A. Section 2. General Health Information (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle “yes” or “no” where appropriate and provide additional information as needed).
1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?
   If yes answer the following:
   - Cigarettes? Age started _____ Age quit _____ Number of packs/day smoked _____
   - Cigars? Age started _____ Age quit _____ Number of cigars/day smoked _____
   - Pipe? Age started _____ Age quit _____ Number of pipe bowls/day smoked _____
   - Did you inhale the smoke?
   - Chewing Tobacco? Number of cans used daily: __________

2. Have you ever had any of the following conditions:
   - Diabetes (☐ Insulin ☐ Pills ☐ Diet)
   - Seizures
   - Trouble smelling odors
   - Claustrophobia (fear of closed-in places)
   - Allergic reactions that interfere with your breathing
   Explain all YES answers

3. Have you ever had any of the following pulmonary or lung problems?
   - Asbestosis
   - Asthma
   - Emphysema
   - Pneumonia
   - Silicosis
   - Lung cancer
   - Chronic bronchitis
   - Broken ribs
   - Pneumothorax (collapsed lung)
   - Tuberculosis
   - Any chest injuries or surgeries
   - Any other lung problem that you’ve been told about?
   Explain all YES answers

4. Do you currently have any of the following symptoms or pulmonary or lung illness?
   - Shortness of breath
   - Shortness of breath when walking fast on level ground, or walking up a slight hill or incline
   - Shortness of breath when walking with other people at an ordinary pace on level ground
   - Have to stop to breath when walking at your own pace on level ground
   - Shortness of breath when washing or dressing yourself
   - Shortness of breath that interferes with your job
   - Coughing that produces phlegm (thick sputum)
   - Coughing that wakes you in early morning
   - Coughing that occurs mostly when you are lying down
   - Coughing up blood in the last month
   - Wheezing
   - Wheezing that interferes with your job
   - Chest pain when you breathe deeply
   - Any other symptoms that you think may be related to lung problems.
5. Have you ever had any of the following cardiovascular or heart problems?
   - Yes  No  Heart attack
   - Yes  No  High blood pressure
   - Yes  No  Stroke
   - Yes  No  Swelling in your legs or feet (not caused by walking)
   - Yes  No  Heart arrhythmia (irregular heart beat)
   - Yes  No  Heart failure
   - Yes  No  Any other heart problem that you have been told about
   - Yes  No  Angina
   **Explain all YES answers**

6. Have you ever had any of the following cardiovascular or heart symptoms?
   - Yes  No  Frequent pain or tightness in your chest
   - Yes  No  Pain or tightness in your chest during physical activity
   - Yes  No  Pain or tightness in your chest that interferes with your job
   - Yes  No  In the past two years, have you noticed your heart skipping or missing a beat
   - Yes  No  Heart burn or indigestion that is not related to eating
   - Yes  No  Any other symptoms that you think may be related to heart or circulation problems
   **Explain all YES answers**

7. Do you currently take medications for any of the following problems?
   - Yes  No  Breathing/lung problem
   - Yes  No  Seizures
   - Yes  No  Heart trouble
   - Yes  No  Blood pressure
   **Explain all YES answers**

8. **If you have used a respirator**, have you ever had any of the following problems?  
   (If you have never used a respirator, check the following space and go to question 9: _____)
   - Yes  No  Eye irritation
   - Yes  No  Anxiety
   - Yes  No  Skin allergies or rashes
   - Yes  No  General weakness or fatigue
   - Yes  No  Any other problem that interferes with your use of a respirator
   **Explain all YES answers**

9. **Yes  No**  Would you like to talk to the health care professional who will review your answers on the questionnaire?  
   **Explain if answered YES**
Questions 10 and 11 below must be answered by every employee who has been selected to use either a full face piece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Do you currently have any of the following eye or ear problems?
   - Yes  No  Wear glasses
   - Yes  No  Wear contact lenses
   - Yes  No  Color blind
   - Yes  No  Have you ever lost vision in either eye (temporary or permanent)
   - Yes  No  If answered yes above, has the problem been corrected?  □ Yes □ No
   - Yes  No  Any other eye or vision problem
   - Yes  No  Wear a hearing aid
   - Yes  No  Difficulty hearing
   - Yes  No  Any other hearing problems
   - Yes  No  Have you ever had an injury to your ears including broken ear drum?
   
   **Explain all YES answers**

11. Do you currently have any of the following musculoskeletal problems?
   - Yes  No  Weakness in any of your arms, hands, legs or feet
   - Yes  No  Have you ever had a back injury
   - Yes  No  Back pain
   - Yes  No  Difficulty in moving your arms and/or legs
   - Yes  No  Pain or stiffness when you lean forward or backward at the waist
   - Yes  No  Difficulty fully moving your head up or down
   - Yes  No  Difficulty fully moving your head side to side
   - Yes  No  Difficulty bending at your knees
   - Yes  No  Difficulty squatting to the ground
   - Yes  No  Difficulty climbing a flight of stairs or ladder carrying more than 25 lbs
   - Yes  No  Any other muscle or skeletal problem that interferes with using a respirator?
   
   **Explain all YES answers**

   Signature of Employee                        Date                   Signature of Physician                    Date

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